opathy or Parkinson's disease. Finally, if other nerves are affected there may be similar psychical troubles, as in chorea, myopathy and Parkinson's disease. Parkinson's disease is a distinctly degenerative malady; there are not only atrophied muscular fibers, but hypertrophied fibers similar to those of myopathy, so that it is placed both by pathological and clinical anatomy in this class.

In conclusion, all of these diseases mentioned with the mental troubles accompanying them, are but diverse manifestations of degeneration, forming a natural group, which the author calls musculo-psychic, of conceptional or hereditary origin; or, another name, *myopsychic* diseases. JELLIFFE.

Neurologisches Centralblatt.

(1902. April 16, No. 8.)

1. Short Communication regarding a New Staining Method for the Central Nervous System. H. VON SCHRÖTTER.
2. A Case of Autochthonous Brain Sinus Thrombosis. DR. GOOD.
3. Further Concerning Asthenic Paralysis with Autopsy (E. Flatau). S. GOLDFLAM,

1. *New Staining Method.*—The use of the Alizarian group of stains, *i.e.*, blue, green, yellow, orange, is applied to nervous tissues with excellent results. A ½ per cent. solution is used for twenty-four hours; the tissues are then differentiated in running (tap) water, treated with obsolute alcohol, etc. This gives a diffuse tissue stain, bringing out all the elements of the nerve tissue.

By using a 3 per cent. solution of the Alizarian solfonal and salt of sodium, and adding a drop of a 5 per cent. oxalic acid solution, orange-yellow color is produced. If the tissue is stained in this and then heated by a 3 per cent. soda solution after washing in distilled water, a good selective stain for the nerve sheath results.

2. *Brain Sinus Thrombosis.*—Good reports a case of extensive sinus thrombosis for which no determining factor could be discovered. After a careful study of the literature he concludes that such cases are not diagnosable.

3. To be continued.

McCARTHY (Philadelphia.)

Neurologisches Centralblatt.

(1902. April 1, No. 7.)

1. Judges and Expert Evidence. H. HOCHE.
2. Cacodylic Acid Therapy. H. SMIDT.
3. Hysteria Problems. RANKE.
4. Asthenic Paralysis, with Autopsy. S. GOLDFLAM.

1. *Expert Evidence.*—A discussion as to the value of a knowledge of medical questions by the Judge, in cases where the expert testimony is indefinite or inconclusive.

2. *Cacodylic Acid Therapy.*—The literature of cacodylic acid as a therapeutic agent in nervous diseases. It has been found of benefit in the following diseases: Neurasthenia, chorea, paralysis agitans, psychoses, etc. Hypodermic use of the drug is recommended, to avoid gastric complications.

3. *Hysteria.*—A controversial paper as to the nature of hysteria and

as to what symptoms are to be considered essential for the diagnosis. It is an answer to a paper on a similar subject by Nissl.

4. To be continued.

McCarthy (Philadelphia).

MISCELLANY.

Hyoscine in Paralysis Agitans. Dr. Judson S. Bury (Lancet, April 19, 1902).

The author says that hyoscine is probably the most useful drug that has hitherto been tried in the treatment of paralysis agitans. As a rule it diminishes or arrests the tremor, checks the troublesome restlessness and the desire to change position, and relieves the "hot flushes" and unpleasant sensations of heat by which these patients are often troubled. It is important to remember, however, that hyoscine is a powerful drug, and one which must be administered with great care. Merck's hyoscine hydrobromate is probably the best preparation, and it is safer to give it by the mouth than to inject it. Quoting from Williamson, he says, "A prescription which is useful is one-eighth of a grain of hyoscine hydrobromate in six ounces of chloroform water. At first two teaspoonfuls of this may be given, then three, four, or five teaspoonfuls. If necessary the dose may be increased to six teaspoonfuls (1-64th of a grain), providing toxic symptoms are not produced. The hyoscine is best given in the morning, just after breakfast, and again in the evening, just before going to bed, if the patient is troubled with restlessness and sleeplessness during the night."

Certain Clinical Types of Brain Syphilis. Pearce Bailey (Medical Record, June 21, 1902).

The most important clinical groups of brain syphilis are the apoplectic, the meningitic, those characterized by isolated oculomotor palsies, and those characterized by somnolence; also those which correspond with the anatomical types of gummata and cerebro-spinal affections. Acute specific meningitis may be suddenly changed by the addition of apoplexy. These acute apoplectic seizures of cerebral syphilis are rather common. The writer believes that cutaneous disturbances of sensibility have been rather more common than usually mentioned in the textbooks, and disturbances of the higher visual tracts distinctly more so; this includes especially bilateral homonymous hemianopsia, which the writer finds frequently of syphilitic origin. Focal signs may be wholly absent in some vascular cases. Often the symptoms of brain syphilis are of gradual, instead of sudden onset. At first they are chiefly mental, the patient becoming irritable, inattentive and forgetful, headache is not prominent, and disturbances in the special brain symptoms are often late in appearing. Somnolence is a frequent and characteristic sign of brain syphilis, improving with the other clinical symptoms, or deepening into coma, as the disease increases. Cases occur characterized by attacks, including those of an epileptoid character, usually focal or Jacksonian, with numerous associated symptoms, such as aphasia, anesthesias, vertigo, or mental symptoms. Disease in the blood vessels usually is found in these patients. General epileptic attacks, or "late epilepsy," are common in brain syphilis. A combination of trauma and syphilis is said to produce a variety of serious conditions. The writer believes that trauma, as a cause of cerebral syphilis, is rare. Syphilis, in its attacks on the central nervous system, has the tendency to make deposits, sometimes microscopic, in both brain and spinal cord. Clinically, the cere-